

Institutionalization of Reproductive Health Preservice Education in the Philippines: An Evaluation of Programmatic Efforts, 1987–1998

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ABBREVIATIONS AND ACRONYMS

ADPCN	Association of Deans of Philippine Colleges of Nursing
AHSE	Associate in Health Science Education
AIDS	Acquired immune deficiency syndrome
APSOM	Association of Philippine Schools of Midwifery
ARH	Adolescent reproductive health
CHED	Commission on Higher Education and Development
CTS	Clinical training skills
DECS	Department of Education, Culture and Sports
DOH	Department of Health
FP	Family planning
GTI	Genital tract infection
HIV	Human immunodeficiency virus
IP	Infection prevention
IUD	Intrauterine device
ModCal™	Modified Computer-Assisted Learning
NGO	Nongovernmental organization
Pap smear	Papanicolaou smear
RH	Reproductive health
STI	Sexually transmitted infection
TRH	Training in Reproductive Health
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

From 1987 to 1998, JHPIEGO, through its Training in Reproductive Health (TRH) Project, collaborated with the Association of Deans of Philippine Colleges of Nursing (ADPCN) and the Association of Philippine Schools of Midwifery (APSOM) to strengthen preservice nursing and midwifery education in the Philippines. Between 1987 and 1994, JHPIEGO initiated activities to strengthen family planning/reproductive health (FP/RH) and enhance trainer/faculty development in five nursing schools and five midwifery schools. By the end of the program in 1998, the number of participating schools increased to 27, and the activities included:

- ◆ Facility needs assessments and refurbishment of FP clinics affiliated with the schools
- ◆ FP/RH clinical skills update courses for providers
- ◆ FP/RH clinical training skills (CTS) courses for faculty and providers at the clinics and schools
- ◆ Production of curricular support materials
- ◆ Procurement of teaching aids and equipment
- ◆ Faculty training in infection prevention, Depo-Provera, reversible FP methods and RH counseling

In February 2001, JHPIEGO conducted an evaluation in the Philippines to assess the impact of the preservice program since its closeout in 1998. The objectives were to determine the current capacity of the participating nursing and midwifery schools to implement the strengthened FP/RH preservice program, and to assess the institutionalization of the interventions. The sample consisted of 16 of the 27 program-affiliated schools: 8 nursing schools and 8 midwifery schools. Responses were obtained from 29 faculty members, 210 students, 16 school principals/deans and 16 school clinic administrators.

The findings show that a core group of faculty trained by JHPIEGO in FP/RH was still working at both the nursing and midwifery schools. Institutionalization of the strengthened FP/RH curriculum in the schools was demonstrated by teaching assignments that took into account faculty training and teaching experience. About 80% of the FP/RH faculty was providing clinical instruction to students and clinical services to clients attending the school clinics. For the most part, only those who had received CTS training were assigned to teach the clinical component of the curriculum.

In addition, at the start of the preservice program, Philippine nursing licensure policies did not allow nurses and midwives to provide certain services such as IUD insertion. Toward the end of the TRH Project in the Philippines, the program staff worked extensively with the Department of Health's (DOH) Family Planning Service to advocate for trained faculty to receive accreditation to provide FP/RH services, including IUD insertion, in the school clinics. In 1999, the DOH, after a review of the training process, recognized the 2-week service provider course and the 3-week FP/RH CTS course conducted by the TRH Project as meeting the national accreditation requirements.

The findings also demonstrate that all schools continued to emphasize a clinical, skill-related component in their FP/RH curriculum. The faculty continued to use the instructor's guides/clinical program guides, teaching materials and teaching equipment for both the classroom and clinical portions of the FP/RH courses. Clinical instructors still utilized competency-based training teaching methods/aids (models and demonstrations were the most



frequently used [96%]). Ninety-four percent of students reported access to anatomic models, and 88% reported that they had sufficient time to practice with models. According to students, competencies for FP/RH skills procedures were assessed with checklists (100% of the midwifery students and 93% of nursing students reported assessment in these areas). The inclusion of FP/RH questions in the licensure examinations signified at the national level the importance of FP/RH content in preservice education. APSOM's and ADPCN's recent efforts in preservice education policy formulation indicate the institutionalization of their leadership role in preservice education.

The school clinics, developed as part of the preservice strengthening program, continued to provide a comprehensive range of FP/RH services, but only offered limited opportunities for students to practice FP/RH skills with clients (FP counseling, breast examination and condom use demonstration were most frequently mentioned by three-quarters of the clinical faculty). More than three-quarters of the students, however, said that clinics provided them with sufficient opportunities to conduct FP/RH procedures. Institutionalization of these school clinics was demonstrated by the expansion of clinic services to include other RH and child health services—prenatal care and well-baby care were the new services most often cited in 13 of the 14 clinics. Institutionalization of the school clinics was also illustrated by all clinics becoming service delivery points for the government's Family Planning Program.

Findings from this evaluation also suggest an impact on FP/RH service delivery and evidence of scaling up. Ninety-three percent of students considered their education as “adequate” to “very adequate” preparation for providing FP/RH services upon employment. Graduates from the preservice program schools performed better on the national licensure examination compared to graduates from other schools. One-half of the schools reported they had a system in place to track the employment status of graduates. Three nursing schools and two midwifery schools used their clinical sites to conduct inservice training, an indication of the recognition of the need for the quality training available from these schools. Some schools were also recipients of donor assistance for RH programs, including HIV/AIDS.

The Philippine nursing and midwifery education system has the capacity to continue implementation of its strengthened preservice education program. This capacity is evident in the availability of trained faculty, the continued implementation of FP/RH curricular components and the availability of adequate clinical training sites. Government and operational policies of schools and public policies (e.g., accreditation) were found to have ensured the maintenance of the capacities developed, indicating institutionalization. Operational policies of schools, however, were seen to affect the degree of institutionalization within the schools. Some findings were more positive for midwifery schools where they used the strategy of teaching FP/RH as a separate course rather than integrating it into existing courses as with the nursing schools. The recently introduced tiered system for healthcare provider courses will affect the preservice program—FP/RH will now be integrated into other courses rather than being taught as a separate course in both the nursing and midwifery schools.

Future areas in which JHPIEGO could provide technical assistance in the Philippines include: strengthening of FP/RH inservice training programs; development of new areas of competency in preservice education; development of school accreditation systems; strengthening human resource policy development; development of a network to provide regional leadership in preservice education; and faculty development to strengthen preservice education.

Institutionalization of Reproductive Health Preservice Education in the Philippines: An Evaluation of Programmatic Efforts, 1987–1998

INTRODUCTION

It is important to JHPIEGO to examine the results of country programs after its assistance has ended. In February 2001, JHPIEGO conducted an evaluation to assess the effectiveness of an 11-year program (1987 to 1998) to strengthen preservice nursing and midwifery education in the Philippines. The objectives were to determine the extent to which program interventions had remained in place in the 3 years since the end of the program, and to assess the institutionalization of the interventions.

Background

Through its Training in Reproductive Health (TRH) Project, JHPIEGO collaborated with the Association of Deans of Philippine Colleges of Nursing (ADPCN) to strengthen nursing education, and with the Association of Philippine Schools of Midwifery (APSOM) to strengthen midwifery education.

Based on weaknesses identified in the needs assessment,¹ the initial phase of the Philippine program (from 1987 to 1994) focused on the following areas:

- ◆ Strengthening family planning/reproductive health (FP/RH) in preservice nursing education
- ◆ Strengthening FP/RH in preservice midwifery education
- ◆ Strengthening trainer/faculty development in preservice nursing and midwifery education

To develop a standardized, competency-based FP/RH curriculum, FP/RH concepts and clinical skills were defined through a consultative process involving experts and stakeholders in preservice nursing and midwifery education. This process resulted in the development of instructor's guides, reference materials and lesson plans. For midwifery schools, APSOM developed the *Instructor's Guide on Family Planning for Schools of Midwifery in the Philippines*. The text incorporates a clinical program guide and it has 17 comprehensive lessons on FP. For nursing schools, ADPCN developed the *Model Instructional Plans in Family Planning*, which comprises nine topics. It also includes a clinical teaching plan for four services that serves as a model teaching plan for other subject matter that the faculty may want to include in their instruction. Both the APSOM and ADPCN instructor's guides recommend teaching methods such as lectures, role plays and group discussion. The guides also suggest use of teaching aids such as flipcharts, posters and anatomic models. To complement the instructor's guides, the TRH Project assisted in the development of reference materials for use by both faculty and students. APSOM developed the *Reference Manual on Family Planning for Schools of Midwifery in the Philippines*. ADPCN developed *Towards Health Through Family Planning: A Manual in Family Planning for Nursing Students in the Philippines Setting* and the *ADPCN Family Planning Anthology*.

¹ The initial needs assessment revealed that competency-based training methods were not being used to teach family planning/reproductive health (FP/RH) in the nursing and midwifery schools, anatomic models were not available for students to practice FP/RH procedures and school-affiliated clinical training sites for FP/RH were inadequate.

The strengthening of nursing education included:

- ◆ Workshops for nursing faculty on FP methods
- ◆ Workshops for nursing faculty on teaching strategies
- ◆ Introduction of competency-based training approaches
- ◆ Preparation of a course syllabus on RH
- ◆ Training skills courses and RH updates for master trainers and nursing school faculty
- ◆ Facility improvement of FP clinics affiliated with five collaborating nursing schools
- ◆ Skills enhancement of faculty service providers
- ◆ Monitoring of clinics to ensure implementation of standardized FP procedures

For midwifery schools, support included:

- ◆ Conducting a training needs assessment of faculty in midwifery schools
- ◆ Workshops on training skills curriculum development
- ◆ Training skills courses and RH updates for master trainers and midwifery school faculty
- ◆ Facility needs assessments and refurbishment of FP clinics affiliated with five collaborating midwifery schools

In the second and final phase of the program (from 1994 to 1998), JHPIEGO, in collaboration with both ADPCN and APSOM, expanded the program to include eight more nursing schools and nine more midwifery schools. The major activities in the 27 program-affiliated schools included:

- ◆ Facility needs assessments and refurbishment of FP clinics affiliated with the schools
- ◆ FP/RH clinical skills update courses for providers
- ◆ FP/RH clinical training skills (CTS) courses for faculty and providers at the FP clinics and schools including CTS for genital tract infection (GTI)
- ◆ Production of curricular support materials
- ◆ Procurement of teaching aids and equipment
- ◆ Faculty training in infection prevention (IP), Depo-Provera, reversible FP methods and RH counseling

In this phase, JHPIEGO initiated efforts to sustain gains made in both the nursing and midwifery preservice education strengthening programs. Program-affiliated schools developed action plans and conducted training of faculty who taught FP at other schools in their region. To improve the sustainability of school clinics, JHPIEGO funded workshops for the school deans to plan for increasing client load and for mobilizing funds. JHPIEGO pursued other new initiatives during this period, including an adolescent reproductive health (ARH) services project to: 1) strengthen RH services at existing clinical training sites to include the provision of ARH services, 2) enhance ARH training in nursing and midwifery schools, and 3) strengthen the linkages between government and non-government counseling services provided at established RH clinical sites.

Another initiative pursued in the final phase was the pilot testing of JHPIEGO's IUD Modified Computer-Assisted Learning (ModCal™). Twenty-eight participants (including faculty members,

service providers, nursing and midwifery students) from six program-affiliated schools participated in the pilot test. The objectives were to assess the acceptability of this innovative learning tool among the various participant groups and to determine institutional support for sustaining computer-assisted learning. The results of the pilot test demonstrated the effectiveness of ModCal as a practical learning tool in preservice education for providing efficient and effective knowledge and skill transfer (Fernandez et al 1999).

An evaluation conducted in September 1995 measured the attainment of program outputs such as improvements in curricular quality of training and quality of services. It concluded that the program had helped preservice initiatives take important steps toward improving institutionalization of FP/RH education (Vollmer, Dean and Valadez 1996).

METHODOLOGY

This assessment built upon a desk review, conducted in the fall of 2000, which examined past JHPIEGO studies conducted in the Philippines and other JHPIEGO Philippine program documents. It is a mixed-method followup study that combined findings from the desk review with data collected from field visits to a sample of nursing and midwifery schools. During the field visits, self-administered questionnaires were given to students and faculty, and interviews were conducted with school administrators and school clinical training site staff.

Purpose and Objectives

The purpose of the assessment was to document progress made in strengthening the nursing and midwifery FP/RH preservice program in the Philippines 3 years after the end of the program. Progress was assessed in two ways: in the capacity of the nursing and midwifery schools to implement the strengthened FP/RH preservice program and in the institutionalization of the interventions introduced by JHPIEGO. Specific objectives included an examination of:

- ◆ Availability of trained FP/RH faculty
- ◆ Implementation of the FP/RH curricular components
- ◆ Utilization of clinical training sites
- ◆ Contributions to FP/RH service delivery and evidence of scaling up

Procedure

The desk review provided the scope and details of JHPIEGO's preservice program in the Philippines. Using the information from the desk review, JHPIEGO developed an evaluation framework and formulated indicators. To develop the study design, JHPIEGO consulted with staff members who had worked on the Philippine program. Subsequently, data collection instruments² were developed and designed, and are listed in **Table 1**.

² Copies of the data collection instruments are on file in the JHPIEGO Research and Evaluation Office.

Table 1. Data Collection Instruments

Instrument	Topics
School information sheet	Enrollment, graduates, licensure examination passing rate, school budget
Classroom tutor questionnaire	Teaching assignments, training(s) attended, use of the standardized FP/RH curriculum, teaching methods, reference materials, teaching materials, experience in using the FP/RH curriculum
Clinical instructor questionnaire	In addition to the above, types of procedures students permitted to do with clients, required competencies, competency measures used, other use of clinical sites
Student questionnaire	Same as above (to validate faculty responses), employment plans
Interview guide for head of school	Faculty training and teaching assignments, experience in using the FP/RH curriculum, information system on school graduates
School clinical training site assessment form	Providers, clinic hours, FP/RH and other health services, equipment and supplies, number of clients, clinic records and reports

Two former Philippines-based JHPIEGO staff members provided technical assistance and participated in the data collection. A JHPIEGO Research and Evaluation Office staff member traveled to the Philippines and together with the two Philippine consultants administered the study instruments from 21 February to 9 March 2001. To cover all 16 schools in the sample during the limited data collection time period, the field study team made 2-day visits to most schools as a 1-person data collection team and to a few schools as a 2-person team. At the end of the data collection period, the initial results of the assessment were presented to the United States Agency for International Development (USAID)/Manila Population, Health and Nutrition Deputy Director. The results were also presented to APSOM and ADPCN representatives. Ideas generated during these discussions have been incorporated into this report.

Sample

The sample consisted of 16 of the 27 preservice program-affiliated schools: eight nursing schools and eight midwifery schools. These schools are the same ones that were included in two earlier evaluation studies conducted by JHPIEGO on other aspects of the Philippine program (Fernandez et al 1999; Vollmer, Dean and Valadez 1996). This sampling allows the findings of this present study to complement the findings of the earlier studies, and provides a broader information base in the overall assessment of the Philippine program.

Because of the limited time for data collection, the field study team distributed faculty questionnaires using convenience sampling. All faculty members available during the 2-day period of the study team's visit were given a questionnaire to complete. Twenty-nine faculty members responded to the questionnaires (16 from the nursing schools and 13 from midwifery schools), which is 47% of the total number of faculty reported to be teaching FP/RH from the start of JHPIEGO's preservice program. The two types of faculty questionnaires, the classroom tutor questionnaire and the clinical instructor questionnaire, were distributed based on teaching responsibility. A faculty respondent who taught both the classroom and the clinical portions of the course responded to both questionnaires. There were 22 faculty respondents for the classroom tutor questionnaire (13 from the nursing schools and 9 from the midwifery schools) and 23 faculty respondents for the clinical instructor questionnaire (12 from the nursing schools

and 11 from the midwifery schools). Sixteen classroom tutor respondents (9 nursing school faculty members and 7 midwifery school faculty members) taught both the classroom and clinical portions of the FP/RH curriculum and, therefore, filled out both questionnaires.

The field study team distributed student questionnaires to all students in the classrooms at the time the study team visited the school. The questionnaire was given to students who were currently taking or had completed the FP/RH courses. Responses were obtained from 170 nursing students, estimated to be 75% of the total number of nursing students who were currently taking or who had completed the FP/RH courses. Responses were obtained from 40 midwifery school students, estimated to be 95% of the total number of midwifery students who were currently taking or who had completed the FP/RH courses.

Responses were obtained from all the 16 school principals/deans and 16 school clinic administrators.

Operational Definitions and Indicators

Capacity refers to the human resources, operating guidelines and infrastructure that enable training institutions to respond to the need for service providers in the health field and produce intended results.

Institutionalization is defined for this assessment as the process by which an organization—that is, a school, government or both—utilizes and maintains the capacities developed through policies, strategic plans, operating systems and procedures.

Indicators for capacity and institutionalization were defined and measured for each of the following areas: availability of trained FP/RH faculty, implementation of the FP/RH curriculum and utilization of school clinics. (See **Appendix** for a complete list of the indicators.)

FINDINGS

The schools varied in enrollment size. Nursing schools had a much higher student enrollment than midwifery schools. The eight nursing schools had an estimated total enrollment of 1,700, while the six midwifery schools reported a total enrollment of 88 students. Two of the eight midwifery schools in the sample had temporarily closed enrollment for the 2000–2001 school year, one because of a lack of students and the other because of the recent sale and ensuing reorganization of the school.³

Information collected from the assessment is described and analyzed below according to the assessment objectives listed under **Purpose and Objectives**.

Availability of Trained Family Planning/Reproductive Health Faculty

Training faculty in effective FP/RH teaching strategies and clinical skills was a key component of the preservice strengthening program. The findings show that a core group of faculty trained in FP/RH was still functioning in both the nursing and midwifery schools. Institutionalization within the schools was demonstrated by teaching assignments that took into account faculty training

³ Anecdotal reports suggest that the recent lifting of the requirement that applicants to 4-year colleges take college entrance examinations has resulted in increased enrollment in 4-year colleges and decreased enrollment in midwifery schools, which are 2-year institutions.

and teaching experience. It was also indicated by government accreditation of clinical faculty that permitted them to provide FP/RH services in the school clinics.

All schools in the sample had at least one full-time trained faculty member (tutor or clinical instructor) assigned to teach FP/RH. More than three-quarters of those teaching FP/RH had received training through JHPIEGO's TRH Project, and they had attended most of the courses offered through the preservice program.

Thirty faculty members were reported to be currently teaching FP/RH in the 16 schools. The eight nursing schools had 17 FP/RH instructors currently teaching or an average of 2.1 per school, and the eight midwifery schools had 13 FP/RH instructors or an average of 1.6 per school.

The TRH Project supported the implementation of eight types of courses aimed to strengthen the FP/RH skills of the faculty. The duration and types of courses were as follows:

- ◆ 2-week FP/RH teaching methods course
- ◆ 2-week service provider course
- ◆ 3-week FP/RH CTS course
- ◆ 5-day ARH course
- ◆ 3-day IP course
- ◆ 2-week GTI course
- ◆ 5-day advanced RH counseling course
- ◆ 2-day natural FP course

More than three-quarters (76%) of the faculty respondents had attended a TRH Project training course. Among those who attended (n=22), almost two-thirds (64%) had attended at least 5 of the 8 courses conducted by the TRH Project. **Table 2** shows the number of faculty who attended TRH Project courses.

Table 2. Distribution of Faculty Respondents by Number of Courses Attended

Number of TRH Project Courses Attended	Nursing (n=15)		Midwifery (n=14)		Both (n=29)	
	n	%	n	%	n	%
5 or more	7	47	7	50	14	48
3 or 4	4	27	2	14	6	21
1 or 2	1	7	1	7	2	7
0	3	20	4	29	7	24

Most of the FP/RH faculty had been trained to teach the clinical portion of the FP/RH curriculum.

Of the total respondents, 55% provided both classroom and clinical instruction, 24% provided clinical instruction only and 21% provided classroom instruction only. Overall, about 80% of the faculty was providing clinical instruction to students and clinical services to clients attending the

school clinics. Midwifery schools had a higher proportion of faculty providing clinical instruction than did nursing schools (**Table 3**).

Table 3. Distribution of Faculty Respondents by Teaching Responsibility

Teaching Responsibility	Nursing (n=16)	Midwifery (n=13)	Both (n=29)	
	n	n	n	%
Classroom and clinical	9	7	16	55
Clinical only	3	4	7	24
Classroom only	4	2	6	21

Schools took into account faculty clinical training skills and years of experience in decisions related to teaching assignments, an indicator that institutionalization of faculty clinical training skills had occurred within the schools.

The 3-week CTS course in FP/RH was considered the training course that faculty members had to attend to teach the clinical portion of the FP/RH curriculum effectively. In each school, at least one of the clinical instructors had attended the 3-week CTS course. Of the 23 clinical faculty respondents, 20 (87%) had attended CTS training. On the other hand, none of the faculty members assigned to teach only the classroom portion had attended the CTS training (**Table 4**). Thus, for the most part, only those who attended the CTS course were assigned to teach the clinical portion of the curriculum. This finding shows that the school administrations considered faculty training when making teaching assignments, indicating that schools recognized the importance of clinical training skills.

Table 4. Faculty Clinical Training Skills by Responsibility: Nursing and Midwifery Schools

CTS Training	Teaching Responsibility (n=29)			
	Clinical or Classroom and Clinical (n=23)		Classroom Only (n=6)	
	n	%	n	%
Attended a FP/RH CTS course	20	87	0	0
Never attended a FP/RH CTS course	3	13	6	100

In addition to having attended CTS training, the faculty members who were assigned to clinical instruction responsibilities were those who had more years of teaching experience. They had an average of seven years of teaching experience as compared to an average of five years experience for those with classroom teaching responsibilities only. Overall, the average FP/RH faculty member had 6.5 years of teaching experience (**Table 5**).

Table 5. Average Years of Faculty Teaching Experience by Teaching Responsibility

Teaching Responsibility	Average Years of Teaching Experience		
	Nursing (n=16)	Midwifery (n=13)	Both (n=29)
Clinical or classroom and clinical	6.9	7.0	6.9
Classroom only	5.0	5.0	5.0
Overall average	6.4	6.6	6.5

Institutionalization was exhibited by government accreditation of clinical instructors as FP service providers in school clinics.

At the start of the preservice program, Philippine nursing licensure policies did not allow nurses and midwives to provide certain services such as IUD insertion. Toward the end of the TRH Project in the Philippines, the program staff worked extensively with the Department of Health's (DOH) Family Planning Service to advocate for trained faculty to receive accreditation to provide FP/RH services, including IUD insertion, in the school clinics. The DOH, after a review of the training process, recognized the 2-week service provider course and the 3-week FP/RH CTS course conducted by the TRH Project as meeting the national accreditation requirements. The DOH subsequently recommended accreditation by the Professional Regulation Commission.

Beginning in March 1999, clinical instructors who completed the required training obtained accreditation, which stated, "she/he is legally authorized to render service in IUD insertion, pill dispensing and provide injectable methods under the authority of the Republic of the Philippines." The Professional Regulation Commission gave accreditation to all JHPIEGO-trained faculty in both program-affiliated and non-program affiliated schools. The DOH also granted participants of the above-mentioned courses an equivalent of 40 units of continuing professional education credits (required for renewing a professional license).

The practice of formal designation of clinical instructors was an indicator that there was institutionalization of the clinical portion of the curriculum.

Only one nursing school clinical faculty member and one midwifery school clinical faculty member reported that they did not have formal designation as clinical instructors. The rest of the faculty providing clinical instruction reported that they had received formal designation as clinical instructors from their school administrator.

FP/RH training opportunities for faculty were reduced after the TRH Project preservice program ended, but faculty took the initiative to stay updated in FP/RH through other means.

At the time of this evaluation, only about one-third of the faculty had attended any FP/RH training in the three years since the end of the preservice program in 1998 (**Table 6**). Although there seemed to be limited opportunities for FP/RH training, the respondents reported a variety of ways to obtain updated FP/RH information. The most often cited sources of new information were journals and books, experts and the Internet.

Table 6. Distribution of Faculty Attendance at Family Planning/Reproductive Health Training During the Past Three Years

Attendance at FP/RH Training	Nursing (n=16)		Midwifery (n=13)		Both (n=29)	
	n	%	n	%	n	%
Yes	6	38	4	31	10	35
No	9	56	7	54	16	55
No answer	1	6	2	15	3	10

Implementation of the Family Planning/Reproductive Health Curricular Components

The TRH Project assisted APSOM and ADPCN in the development and implementation of a standardized, competency-based FP/RH curriculum for nursing and midwifery schools. During this evaluation, all schools were still using the instructional materials developed through the preservice program. The faculty continued to implement the FP/RH curricular components with instructor's guides, teaching materials and teaching aids (e.g., models, videos). The strategies used to implement the FP/RH curriculum, however, differed between the nursing and midwifery schools. Nursing schools used an "integration" strategy in which FP/RH was taught as a component of selected nursing courses. Midwifery schools used a strategy where FP/RH was taught as one separate course.

The importance of FP/RH curricular content was indicated at the national level by the inclusion of FP/RH questions in the nursing and midwifery licensure examinations. Institutionalization was indicated through the leadership of APSOM and ADPCN in preservice policy development.

Capacity existed in the implementation of the classroom portion of the standardized FP/RH curriculum.

All nursing and midwifery schools reported using the FP/RH course outline, course syllabus and instructor lesson plans developed by ADPCN and APSOM, respectively, with assistance from the TRH Project. Most (82%) of the classroom tutors reported using the instructor's guide "always." Specifically, for midwifery schools, all classroom tutors reported using the instructor's guide "always." For nursing schools, two-thirds of classroom tutors used the instructor's guide "always," and the remaining one-third reported using the instructor's guide only "sometimes." This difference may be because the instructor's guide for midwifery schools was developed to cover all topics, while the guide for nursing schools was developed only for selected FP topics.

Most (73%) of the classroom tutors reported ease in teaching "all or most topics" in the instructor's guide. Again, midwifery schools had a higher proportion of tutors reporting ease in teaching "all or most topics" (**Table 7**).

Table 7. Distribution of Use of Instructor's Guide and Ease in Teaching Family Planning/ Reproductive Health Topics

Indicator	Nursing (n=13)		Midwifery (n=9)		Both (n=22)	
	n	%	n	%	n	%
Always use guide	9	69	9	100	18	82
Sometimes use guide	4	31	0	0	4	18
Ease in teaching all or most topics	8	62	8	89	16	73

Capacity existed in competency-based FP/RH clinical instruction.

All schools had a clinical, skill-related component in the FP/RH curriculum. All clinical instructors, with the exception of one clinical instructor in a midwifery school, reported using the clinical program guide and using measurable learning objectives for teaching the clinical portion of the FP/RH curriculum. When asked to enumerate competencies expected from students, most of the clinical instructors (83%) were able to identify the competencies correctly (**Table 8**).

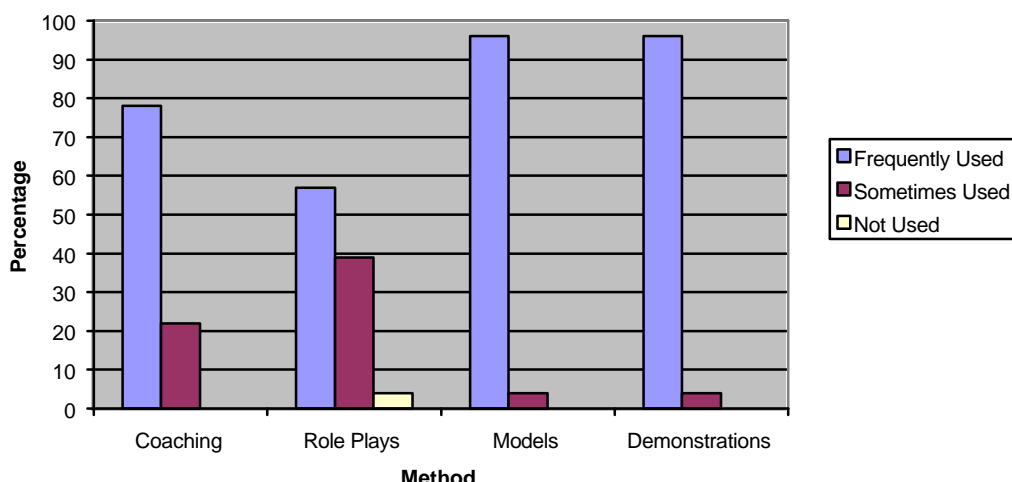
Table 8. Clinical Instructors' Use of Clinical Program Guide, Use of Measurable Learning Objectives and Satisfactory Identification of Student Competencies

Indicator	Nursing (n=12)		Midwifery (n=11)		Both (n=23)	
	n	%	n	%	n	%
Use of clinical program guide	12	100	10	91	22	96
Use of measurable learning objectives	12	100	10	91	22	96
Satisfactory identification of student competencies	10	83	9	82	19	83

Faculty continued to use the competency-based training teaching materials, methods/aids and equipment provided by JHPIEGO for teaching both the classroom and clinical portions of the FP/RH courses.

All 16 schools reported using the teaching materials provided by the preservice program, which consisted of RH flipcharts and posters. All schools had at least one each of the following teaching aids made available through the program: breast model, pelvic model, handheld uterine model and condom model. Training equipment, including training videos and videocassette recorders, overhead projectors and film projectors, were also still in use. All schools had functional videocassette recorders, and all nursing schools reported having a functional overhead projector available for teaching. Five midwifery schools had functional overhead projectors, while the other three midwifery schools reported overhead projectors that were in a "condition that limits its use." Coaching, role plays, anatomic models for simulations and demonstrations were often used in clinical instruction by the clinical instructors. Models and demonstrations were the most frequently used teaching methods/aids reported by clinical instructors (96%). Role plays were the least used (**Figure 1**). The most common reason cited for not using role plays was lack of time.

Figure 1. Distribution of Teaching Methods/Aids Used in Clinical Instruction: Nursing and Midwifery Schools (n=23)



Students reported that competencies for FP/RH skills were assessed. Checklists were used in competency assessments. Students practiced FP/RH procedures with anatomic models. These practices are indicators that competency-based FP/RH instruction has been institutionalized in most schools.

The field study team determined that all midwifery and nursing schools, with the exception of one nursing school for which the data were insufficient, assessed student competency for FP/RH skills procedures at the end of the students' clinical rotations. All students in the midwifery schools and 93% of students in the seven nursing schools for which there were data reported being assessed for competency in FP/RH skills (**Table 9**). Checklists were used for these competency assessments. Most students (94%) reported access to anatomic models, and most students (88%) reported that they had sufficient time to practice with the models (**Table 9**). Although both cadres of students had good access to anatomic models, nursing students had more difficulty getting sufficient practice time with the models.⁴ Among nursing students, 54% reported that they were assessed as competent in performing a pelvic examination with a model compared with 100% of midwifery students. Sixty percent of nursing students reported they were assessed as competent in IUD insertion with a model compared with 98% of midwifery students.

⁴ Note that the number of nursing students enrolled was much higher than the number of midwifery students. The higher ratio of nursing students to number of models available may have restricted their access to models more so than for the midwifery students.

Table 9. Student Assessment on Use of Competency-Based Approaches

Indicator	Nursing Students ^a (n=140)		Midwifery Students (n=40)		Both (n=180)	
	n	%	n	%	n	%
Assessed as competent in FP/RH skills at the end of clinical rotation	130	93	40	100	170	94
Use of checklist in FP/RH skills assessments	130	93	40	100	170	94
Access to anatomic models	130	93	39	98	169	94
Sufficient time to practice with anatomic models	119	85	40	100	159	88

^a One nursing school was dropped because of non-response to the question that asked students whether they were assessed as competent in FP/RH skills at the end of clinical rotation (54% non-response rate).

The school libraries had a sufficient supply of FP/RH reference materials, and students were required to use them, confirming that there was institutionalization of the FP/RH curriculum.

Most students (81%) considered the FP/RH reference materials in the libraries sufficient. A higher proportion of students from midwifery schools reported sufficiency in library materials as compared to nursing school students. Overall, two-thirds of the students reported that they were required to read the FP/RH reference materials. A much higher percentage of students from midwifery schools (98%) reported being required to read reference materials as compared to those from nursing schools (59%). (See **Table 10.**) Reading requirements may have been easier to carry through/enact in midwifery schools as compared to nursing schools because FP/RH was taught as one course in midwifery schools.

Table 10. Students Reporting Sufficient Library Reference Materials and Requirement to Read Reference Materials

Indicator	Nursing (n=170)		Midwifery (n=40)		Both (n=210)	
	n	%	n	%	n	%
Sufficient FP/RH reference materials in library	133	78	36	90	169	81
Requirement to read FP/RH reference materials	101	59	39	98	140	67

The importance of FP/RH content in preservice education was signified at the national level by the inclusion of FP/RH questions in the national licensure examinations.

Both the nursing and midwifery licensure examinations included FP/RH questions. The inclusion of FP/RH questions in the licensure examinations shows that FP/RH knowledge is a critical requirement for nurses and midwives to obtain a license. This inclusion then ensures that the nursing and midwifery curricula contain FP/RH content and may provide an incentive to TRH program schools to continue to use, and institutionalize, the strengthened FP/RH curricular components.

In 1994, computerization was implemented for the nursing licensure examination, formally called the Integrated Comprehensive Nurse Licensure Examination. In this system, examination

questions are selected through a computer-based, randomization process from a bank of test questions. The Board of Nursing, the government body responsible for nursing licensure, determines the questions included in the test question bank. The questions cover the concepts that are specified in the syllabi of courses such as fundamentals of nursing, medical-surgical nursing, maternal and child health nursing, psychiatric nursing, community health nursing and professional adjustment nursing. In a 1994 board resolution, the Board of Nursing specified that FP and related concepts were to be included in the syllabi and correspondingly in board examination questions under maternal and child health nursing. Other FP and related concepts were also included in the fundamentals of nursing and community health nursing sections.

Institutionalization of the leadership role of APSOM and ADPCN in preservice education policy development was illustrated in recent association-led efforts in preservice policy formulation.

At the time of the evaluation, the president of APSOM served as the Chairman of the Technical Committee on Midwifery Education of the Commission on Higher Education and Development (CHED). During the last three years, APSOM and the Technical Committee on Midwifery Education of the CHED led the development of updated policies and standards for midwifery education and issued the CHED Memorandum Order in December 2000. The order outlines new policies and standards related to school administration and faculty, curriculum, instructional standards, library facilities, clinical facilities and student selection. Complementing APSOM's leadership in preservice midwifery education policy development was its faculty development programs and activities. In May 2001, APSOM held a 3-day national conference for its members. One of the conference activities was an update on FP/RH. APSOM and ADPCN also contributed to the recognition on behalf of the Board of Nursing of the need to include FP/RH questions on the nursing licensure examination.

At the time of the evaluation, the Technical Committee for Reproductive Health of ADPCN, with assistance from the CHED, was developing updated policies and standards for nursing education. A memorandum order on the new policies and standards, which will be similar to the one developed by APSOM for midwifery education, was expected to be issued by the CHED before the end of 2001. Likewise, ADPCN conducted updates and refresher courses in FP for the nursing faculty in May 2001.

Recent preservice education policies provide opportunities for APSOM and ADPCN to strengthen their roles in accreditation. At the same time, these policies pose a challenge to FP/RH instruction brought about by the integration of FP/RH into other courses.

Accreditation opportunities for APSOM are defined in the CHED Memorandum Order in the areas of school operations, faculty certification and clinical sites accreditation. Although the approval to open schools is a responsibility of the CHED, continued school operation requires accreditation by the APSOM Accreditation Board. In addition, faculty members are required to be certified to teach and the National Midwifery Education Certification Council of APSOM issues this certification. Schools are required to have a faculty development program that includes clinical skills enhancement for at least two weeks a year. The CHED Memorandum Order stipulates appropriate, updated syllabi and instructional methods and strategies implemented through a system of supervision and evaluation. The clinical portion of the course can be conducted using hospitals that have been accredited by the DOH or clinics that have been accredited by the APSOM Accreditation Board.

The curriculum described in the recent CHED Memorandum Order is consistent with a recently adopted policy instituting a 2-year Associate in Health Science Education (AHSE) program. The

AHSE program is the initial tier in a multi-tiered education system leading to a baccalaureate degree in the health profession. In this system, students enrolling for a degree in nursing or a certificate in midwifery need to complete the AHSE program in their first two years. Students then take additional courses to complete their degree or certificate in subsequent years. The implication of the AHSE program on FP/RH instruction in midwifery schools is that FP/RH will no longer be taught as a separate course but will be integrated into other courses. The effect of this integration on the quality of FP/RH instruction in midwifery schools remains to be seen.

Utilization of Clinical Training Sites

The TRH Project set up school clinics for FP/RH services as venues for students to practice FP/RH procedures; assistance included procurement of clinic equipment. The school clinics have continued to provide FP/RH services to clients as well as opportunities for students to provide services. The expansion of clinical services to include other RH and child health services enhanced institutionalization of school clinics. The expansion to non-FP/RH service delivery may be considered scaling-up, making the school clinics more viable and contributing to their institutionalization. Institutionalization of the school clinics was also demonstrated by all clinics becoming service delivery points for the government's Family Planning Program.

The school clinical sites were well equipped and provided a comprehensive range of FP/RH services.

There were two types of school clinics: (1) clinics attached to hospitals or hospital-based clinics and (2) freestanding or community-based clinics. The field study team collected data at 14 clinics, which were equally divided between hospital- and community-based clinics. More nursing school clinics (5 of 8) were community-based, while more of the midwifery school clinics (4 of 6) were hospital-based (**Table 11**).

Most clinics (11 of 14) were open five days a week from Monday to Friday, and some clinics were also open on Saturday. On average, clinics were open 36.7 hours per week or about seven hours per workday (**Table 11**). More than half of the clinics (57%) were open 40 or more hours per week. Only one clinic reported closing for a 6-week period during the year in which providers went on vacation. School clinics had an average of about 5 FP/RH clients per week, a low caseload for these services.⁵ This low caseload obviously has implications for student exposure to FP/RH procedures during their clinical rotations and the length of time it takes students to achieve competency.

School clinics had an average of 2.8 providers on site during the day (**Table 11**). Hospital-based clinical staff usually included physicians undergoing a residency program.

⁵ At least one school clinic made special efforts to recruit additional FP/RH clients during the period of students' clinical rotations.

Table 11. Characteristics of School Clinics

Indicator	Nursing (n=8)	Midwifery (n=6)	Both (n=14)
Hospital-based school clinics	3	4	7
Community-based school clinics	5	2	7
Average number of hours open per week	34.6	39.5	36.7
Average number of FP/RH clients per year	221	252	237
Average number of health providers	3.0	2.7	2.8

The clinics provided a broad range of FP services that included IUD insertion and removal, oral contraceptives, condoms, injectable contraceptives and natural FP services. All clinics reported that these services were “always available in the last 6 months.”

Clinic equipment provided by the program was still available and functional. All school clinics had the following equipment:

- ◆ Examination table with stirrups
- ◆ Adjustable gooseneck lamp
- ◆ IUD kits
- ◆ Blood pressure apparatus
- ◆ Stethoscope
- ◆ Weighing scale
- ◆ Microscope
- ◆ Steamer/sterilizer
- ◆ Plastic container for decontamination solution
- ◆ Plastic container for disposal of waste
- ◆ Sink with running water

The school clinical sites appeared to provide limited opportunities for students to practice FP/RH skills with clients. Students provided some key FP/RH services frequently, but not all key FP/RH services.

Clinical instructors were asked to comment on which FP/RH skills students were able to practice in the clinic and how often. About three-quarters of the clinical instructors reported that the FP/RH procedures that students conducted most frequently were FP counseling, breast examination and condom use demonstration. About three-quarters of midwifery clinical instructors and one-half of nursing clinical instructors reported that students frequently dispensed pills. Only one-third of the nursing clinical instructors and one-half of midwifery clinical instructors, however, reported that students administered Depo-Provera frequently.⁶ A quarter of the nursing clinical instructors reported that nursing students did not provide ARH counseling services at all. In general, it was reported that students did not perform pelvic examinations frequently, although midwifery students appeared to do so more often than did nursing students. One-third of clinical faculty respondents from both sets of schools said students never conducted a pelvic examination. Both nursing and midwifery students did GTI

⁶ Caseload may have been low for this and certain other FP services.

testing and counseling the least frequently, with half of the clinical faculty respondents reporting that students never performed this procedure during clinical rotation⁷ (Table 12).

Table 12. Procedures Conducted by Students in Clinics as Reported by Clinical Instructors

Procedure	Procedures Conducted by Students					
	Frequently (%)		Sometimes (%)		Not Conducted (%)	
	Nurse (n=12)	Midwife (n=11)	Nurse (n=12)	Midwife (n=11)	Nurse (n=12)	Midwife (n=11)
FP counseling	67	73	25	27	8	0
Breast examination	83	73	17	18	0	9
Condom use demonstration	75	73	17	27	8	0
Depo-Provera injection	33	54	50	9	17	36
Pill dispensing	58	73	25	18	17	9
Pelvic examination	33	45	33	18	33	36
GTI testing and counseling	25	18	25	27	50	54
ARH counseling	25	45	50	36	25	18

Most nursing and midwifery students felt that school clinics provided them with sufficient opportunities to conduct FP/RH procedures and FP/RH counseling with clients.

More than three-quarters of students said clinics provided them with sufficient opportunities to conduct FP/RH procedures. A higher proportion, about four-fifths, reported clinics provided the opportunity to conduct FP/RH counseling. A higher proportion of midwifery students said clinics provided sufficient opportunities to conduct FP/RH procedures and counseling as compared to nursing students (Table 13).

Table 13. Students Reporting Sufficient Opportunities to Perform Family Planning/ Reproductive Health Procedures and Counseling in Clinics

Indicator	Nursing (n=170)		Midwifery (n=40)		Both (n=210)	
	n	%	n	%	n	%
Sufficient opportunities for FP/RH procedures	128	75	37	93	165	79
Sufficient opportunities for FP/RH counseling	133	78	40	100	173	82

School clinics have maintained quality standards for FP/RH service delivery.

School clinics were still adhering to the quality standards established at the time of the program. The clinics were observed to be using appropriate IP practices and ensuring the privacy of clients. Most (93%) were found to be recording all FP methods dispensed on clients' medical records (Table 14).

⁷ It is possible that student exposure to GTI service provision was minimal because of low caseload as well as because students might not have been permitted to do testing.

Table 14. Quality Practices of School Clinics

Indicator	Nursing (n=8)		Midwifery (n=6)		Both (n=14)	
	n	%	n	%	n	%
Equipment and gloves soaked properly	8	100	6	100	14	100
Use of separate room or curtains in counseling areas	7	88	6	100	13	93
Client records filled out with FP method dispensed	8	100	5	83	13	93

School clinics provided other RH and child health services in addition to FP services. These services enhanced institutionalization of school clinics.

As previously mentioned, as part of the preservice strengthening program the TRH Project set up the school clinics for FP/RH services as venues for students to practice FP/RH procedures. The expansion to include non-FP/RH services may help to make the school clinics more viable, and contribute to institutionalization of the clinics.

Almost all clinics (13 of 14) provided services other than FP, with prenatal care and well-baby care being the most frequently mentioned. Five clinics (2 nursing and 3 midwifery) provided normal delivery care. Other FP/RH-related services that were often reported included counseling for infertility cases and testing for pregnancy.

The volume of non-FP services tended to be high, as shown in the two clinics where year 2000 data were available. A hospital-based midwifery school clinic reported 280 FP visits (or services provided) per year, but also reported 4,500 prenatal care, 550 Papanicolaou (Pap) smear and 300 postabortion care cases. The other clinic, a community-based midwifery school clinic, reported 3,500 clients, approximately one-third (1,100) of which were FP clients.

School clinics were service delivery points of the government's Family Planning Program, and thus were regularly provided with FP supplies. This finding attests to the institutionalization of FP services in school clinics.

The DOH formally recognized the school clinics as service delivery points for FP, and as such, they became service delivery points of the DOH's Family Planning Program. Accordingly, they received regular contraceptive supplies from the DOH including pills, IUDs, Depo-Provera and condoms. In addition, because they were service delivery points, these clinics were included in the DOH contraceptive logistics management system as receiving units, and obtained quarterly deliveries of these FP supplies. This recognition contributed to the institutionalization of the clinics.

Contributions to Family Planning/Reproductive Health Service Delivery and Evidence of Scaling Up

Information obtained from this evaluation suggests that graduates of the strengthened preservice program were adequately prepared to provide FP/RH services.

Some schools recognized the need to know how well FP/RH preservice education responded to the needs for FP/RH service delivery and initiated studies that tracked the employment status of graduates. At the same time, certain schools utilized their strengthened capacities in preservice



education for inservice training. In addition, some used these capacities to expand to non-FP applications.

Students of the strengthened preservice education program considered themselves adequately prepared to provide FP/RH services when they enter the workforce.

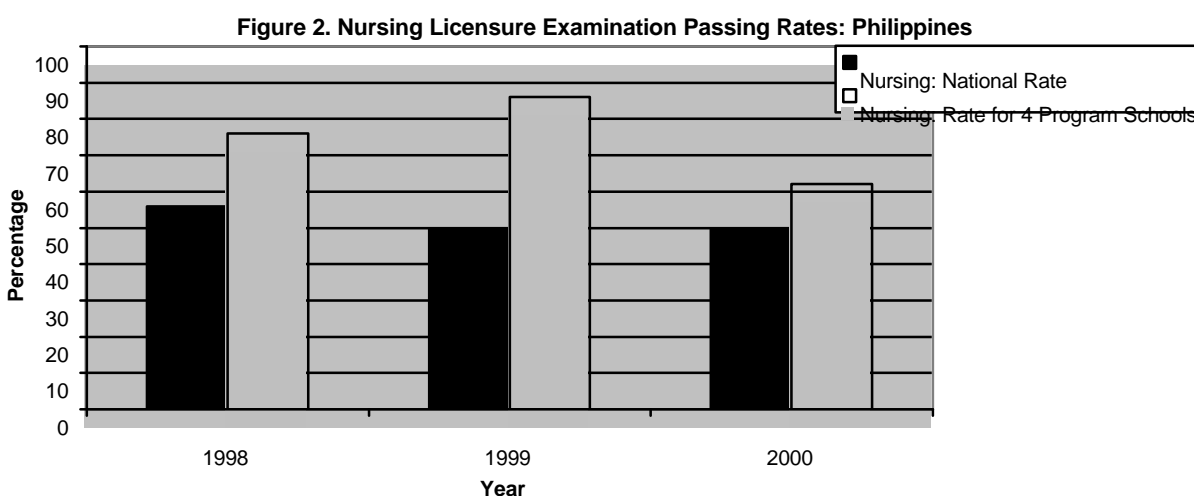
Students reported they had adequate preparation to provide FP/RH services when they enter the workforce; most (93%) of the students considered their education as “adequate” to “very adequate.” A higher proportion of midwifery students reported “very adequate preparation” (58%) as compared to nursing students (27%). In addition, none of the midwifery school respondents assessed their training as “inadequate,” whereas 13 nursing students (most of these students were from one school) considered their preparation inadequate (**Table 15**). There was no opportunity to ask the students why such a response was given.

Table 15. Adequacy of Training According to Students

Student Assessment	Nursing (n=170)		Midwifery (n=40)		Both (n=210)	
	n	%	n	%	n	%
Very adequate preparation	45	27	23	58	68	32
Adequate preparation	112	66	17	43	129	61
Inadequate preparation	13	8	0	0	13	6

Graduates of the strengthened preservice education program schools performed better on the national licensure examination than graduates from other schools.

The average national passing rate and the average passing rate of a sample of four strengthened preservice education program nursing schools visited by the study team are compared for the years 1998, 1999 and 2000 in **Figure 2** below. The average passing rates of the graduates from the strengthened preservice program nursing schools have been consistently higher over time than the national average of the nursing schools, suggesting improved preparation for service provision.



The nursing school graduate passing rates shown here for the strengthened preservice program schools were based on four schools where data were complete. Passing rates for these four schools were calculated by comparing the total number of graduates with the number of graduates who passed the examination. Passing rates at the national level were based on the number of graduates who took the examination. **Table 16** below presents the numbers of graduates associated with the passing rates.

Table 16. Nursing Licensure Examination: Numbers of Graduates Who Passed the Examination

Rates	1998		1999		2000	
	Total Number	Passing Number	Total Number	Passing Number	Total Number	Passing Number
National Rates*	17,101	9,541	13,152	6,559	9,271	4,602
Program School Rates**	239	182	214	185	128	79

*Base number is the number of students who took the examination that year.

**Base number is the number of students who graduated that year.

As can be seen in **Figure 2** and **Table 16**, the preservice program school passing rates were repeatedly higher than the national passing rates. In 1998, 182 nursing school graduates (76%) passed the examination out of a total of 239 who ever graduated. In 1999, 185 nursing school graduates (86%) passed out of a total of 214 who ever graduated, and in 2000, 79 nursing school graduates (62%) passed out of 128 who ever graduated.

Students preferred to seek employment in the public rather than private sector after graduation, suggesting that the public sector may have benefited more than the private sector from the preservice strengthening program.

Nursing and midwifery students ranked government hospitals as the most desirable place for employment after graduation. The majority of students ranked government health centers as the next most preferred place for employment. Private health facilities, including FP nongovernmental organizations (NGOs), were the least desirable places for future employment. Nursing students generally preferred hospital employment, while midwifery students showed a greater preference for health center employment (**Table 17**). The preference for government employment is attributed to the higher salaries in the public sector.

Table 17. Student Preferences for Place of Employment After Graduation

Employer	Percentage of Students by Rank			
	Rank 1		Rank 5	
	Nursing Students (n=170)	Midwifery Students (n=40)	Nursing Students (n=170)	Midwifery Students (n=40)
Private hospital	24	8	24	41
Private maternity clinic	6	5	40	24
Government hospital	67	44	4	6
Government health center	17	34	15	3
FP NGO	11	11	33	23

Five schools were conducting inservice training programs, an indication of the local recognition and need for the quality training available from these schools.

Three nursing schools and two midwifery schools reported that they had used their clinical sites to conduct FP/RH inservice training for DOH or local government service providers. One of the midwifery schools reported that it had trained between 60 to 70 participants during the past three years, and the other reported to have trained 100 participants. The schools provided these inservice trainings in response to requests made by the local governments.

The above is an important finding because it demonstrates the independent initiative taken by these five schools to pursue inservice training opportunities after the preservice program ended. It attests to the strong leadership of the school principals and faculty as well as their interest in building partnerships with local government entities. This finding also illustrates the initiative taken by local government entities to identify sources of training. Overall, it indicates that there is recognition and need for the quality training provided by these schools.

Anecdotally, the head of a midwifery school that was conducting inservice FP/RH training noted that graduates from schools offering the strengthened preservice curriculum required less FP inservice training than providers who had not been educated with the strengthened curriculum. Specifically, the graduates from schools with the strengthened preservice curriculum completed the didactic portion of the inservice FP training, which is designed for eight days, in five days, and the practicum portion, designed for six days, in three days.

Building on capacities developed in the preservice strengthening program, four schools were implementing donor-assisted RH programs.

One nursing school reported implementing an ARH program in collaboration with the local division of the Department of Education, Culture and Sports (DECS). In this program, faculty provided training for school nurses to provide ARH counseling and services to high school students. Another nursing school received funding from the Japan International Cooperation Agency to develop and implement a sexually transmitted infection (STI)/HIV/AIDS behavioral practices surveillance project. The same school obtained USAID assistance for the development and implementation of a STI/HIV/AIDS community outreach prevention and treatment program. Another nursing school used its clinical site to conduct training for providers from a NGO on HIV/AIDS client care and support and on Pap smear procedures. A midwifery school obtained funding from the Joint United Nations Programme on HIV/AIDS to develop and implement a program that would build on the capabilities of youth groups to promote HIV/AIDS prevention.

Half of the schools had a system in place to provide information on employment status of graduates. A few schools were conducting formal studies to track employment of graduates.

One-half of the schools reported that they had a system to track employment status of graduates (**Table 18**). The information was reported to be maintained by the alumni affairs units of the schools. Two schools (one each for nursing and midwifery, both state-funded institutions) were conducting school-funded research studies that track employment of graduates. These studies also looked into the factors that affect employment status.

Table 18. Information on Graduate Employment Status at the Schools

Graduate Employment Status	Nursing (n=8)		Midwifery (n=8)		Both (n=16)	
	n	%	n	%	n	%
With information	3	37	5	63	8	50
Without information	5	63	3	37	8	50
Total	8	100	8	100	16	100

DISCUSSION AND CONCLUSION

As part of this evaluation, the field study team visited sixteen out of the 27 schools included in the strengthened preservice program. Findings revealed that the program's investment has been maintained three years after external funding ceased. In some cases, there had even been a spillover effect into new areas—including expansion of services at school clinics to include other RH clinical services. Five schools were using their clinical sites to conduct inservice training for both government and nongovernmental health providers, and four schools were recipients of donor assistance for RH programs. The latter four schools utilized their capacities in FP/RH preservice education to develop and implement programs in other areas of RH such as ARH and STI/HIV/AIDS prevention. The school clinical sites and related community outreach activities served as the implementing mechanisms for these programs. Half of the schools also had a system in place to track employment status of graduates.

A key finding is that the Philippine nursing and midwifery education system has the capacity to continue implementation of its strengthened preservice education program. This capacity is evident in the availability of trained faculty, the continued implementation of FP/RH curricular components developed jointly by JHPIEGO, APSOM and ADPCN and the availability of adequate clinical training sites. The schools' clinical training sites have now become part of the government's Family Planning Program, ensuring that supplies will be readily available. In addition, equipment and materials provided through the program to the schools for teaching in the classroom and in school clinics were still in place. Anatomic models were available for student practice, the school libraries had a sufficient supply of FP/RH reference materials that were still in use by students and the school clinical sites were well equipped to provide FP/RH services. Most students reported that faculty assessed their competencies in FP/RH skills at the end of their clinical rotations and used checklists, which demonstrates that the competency-based approach to training in FP/RH has been institutionalized in the schools.

Government and operational policies of schools were found to have ensured the maintenance of the capacities developed, indicating institutionalization of the preservice interventions. Operational policies of schools also affected the degree of institutionalization of the interventions within the schools. Institutionalization of the FP/RH curricular components was observed to be slightly greater in midwifery schools where they used the strategy of teaching FP/RH as a separate course compared to nursing schools where FP/RH material was integrated into existing courses. The development of a more detailed and comprehensive instructor's guide and reference materials for midwifery schools was also considered as contributing to the greater institutionalization observed in these schools.

Overall, institutionalization of preservice program interventions was found to be high at both the nursing and midwifery schools visited. Smaller proportions of nursing school students, however, reported having sufficient opportunities to practice FP/RH procedures and counseling in the clinics compared with midwifery school students. Nursing students were also less likely than

midwifery students to report they had sufficient time to practice with anatomic models, sufficient FP/RH reference materials in the library or requirements to read FP/RH reference materials for their courses.

The nursing school faculty was less likely than the midwifery school faculty to report always using the FP/RH instructor's guide and to be at ease teaching all or most topics included in the guide. Even though some of the results for the nursing schools appeared to be less positive than those for the midwifery schools, faculty at both schools were using the curricular materials and competency-based approach most of the time.

Importantly, students of the strengthened preservice education program schools, both nursing and midwifery, reported that they felt well prepared to provide FP/RH services when they enter the workforce. The high percentage of nursing graduates from program schools who passed the national licensure examination in comparison with national passing rates lends support to this finding.

As important as evidence of school-level institutionalization of the preservice program interventions was the development of new public policies, in the form of accreditation of clinical instructors as service providers and inclusion of FP/RH questions in licensure examinations. These policies illustrate the increased recognition of the importance of the FP/RH content included in the preservice strengthening program. Recent policies introducing changes in the nursing and midwifery curriculum, including a "tiered" system for health provider courses, may, however, pose a challenge to the gains made in the preservice strengthening program, especially in midwifery schools. In the tiered system, FP/RH will be taught in both the nursing and midwifery schools as course components in a number of courses and not as a separate course, as is currently done in midwifery schools. The new policies, on the other hand, do provide opportunities for both APSOM and ADPCN to strengthen FP/RH preservice education further (e.g., taking on an expanded role in school accreditation).

Implications for the Future

To preserve the gains made and to build on the scaling up of the preservice strengthening program in the Philippines, JHPIEGO could provide technical assistance in the following areas:

- ◆ *Development of FP/RH inservice training programs that utilize the capacities in FP/RH preservice programs*

The FP/RH faculty in the preservice institutions could serve as inservice trainers, a practice already taking place in some schools. The school clinics could be utilized as clinical sites to implement a quality of care program for providers from government organizations and NGOs.

- ◆ *Development of new areas of competencies in preservice education*

The capacities that exist in the FP/RH curriculum can serve as building blocks toward strengthening the curriculum in other areas such as postabortion care, HIV/AIDS and maternal and neonatal care. At least one school is already demonstrating development in this area.

- ◆ *Development of school accreditation systems including clinical training sites accreditation*

The new policies in preservice education provide an expanded role for APSOM and ADPCN in school accreditation. Guidelines, systems and procedures will have to be developed to support this expanded role.

◆ *Strengthening human resource policy development*

This area includes the need for a national policy and a strategic plan to ensure a steady supply of health human resources, including the development of a policy research agenda. This area may involve the development of information systems that quantify manpower and training needs and document and track graduates and participants. It may also involve the review of the incentive system for health manpower. Efforts in human resource policy development will require working with government institutions such as the DOH and DECS.

◆ *Development of a network to provide regional leadership in preservice education*

The Philippines may be in a good position to take on a leadership role in the development of a regional network to share best practices in preservice education by developing a repository of training technology documentation and by facilitating regional sharing of experiences.

◆ *Faculty development to strengthen preservice education further, such as:*

- Development of a system of continuing education in FP/RH for faculty
- Development of a system of monitoring and supervision of trained faculty
- Development of a system for training new inflow of faculty

Conclusion

This evaluation found that, three years after the TRH preservice education program ended in the Philippines, the nursing and midwifery schools have the capacity to continue implementation of their strengthened preservice education programs. This capacity is evident in the availability of trained faculty, the continued implementation of FP/RH curricular components and the availability of adequate clinical training sites. Government and operational policies of schools and public policies (e.g., accreditation) were found to have ensured the maintenance of the capacities developed, indicating institutionalization.

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APPENDIX A

Capacity and Institutionalization Indicators

Capacity Indicators

Availability of Trained FP/RH Faculty

- ◆ Proportion of schools having at least one full-time faculty member assigned to teach FP/RH
- ◆ Proportion of FP/RH faculty trained in TRH Project courses
- ◆ Proportion of FP/RH faculty who attended at least 5 of the 8 TRH Project courses
- ◆ Proportion of faculty assigned to teach the clinical portion of the FP/RH curriculum
- ◆ Proportion of schools in which FP/RH clinical instructors received formal FP/RH training

Implementation of the FP/RH Curriculum

- ◆ Proportion of schools still using instructional materials developed by the program
- ◆ Proportion of schools in which standardized course outline is used for the FP/RH course
- ◆ Proportion of schools in which a syllabus has been followed for the FP/RH course
- ◆ Proportion of schools in which instructor lesson plans have been used for the FP/RH course
- ◆ Proportion of faculty using the classroom and clinical instructor's guides developed by the program
- ◆ Proportion of faculty reporting ease in teaching all or most topics in the instructor's guide
- ◆ Proportion of schools in which curriculum includes clinical skills component
- ◆ Proportion of clinical instructors using clinical program guide in teaching clinical portion of course
- ◆ Proportion of clinical instructors using measurable objectives in teaching clinical portion of course
- ◆ Proportion of clinical instructors able to identify appropriately competencies students need to develop in clinical rotation
- ◆ Proportion of clinical instructors using anatomic models and demonstrations
- ◆ Proportion of schools in which at least one condom model is available for use
- ◆ Proportion of schools in which at least one pelvic model is available for use
- ◆ Proportion of schools in which at least one uterine model is available for use
- ◆ Proportion of schools in which at least one breast model is available for use
- ◆ Proportion of schools in which a videocassette recorder is available for teaching

Utilization of School Clinics

- ◆ Proportion of schools with school clinic in operation
- ◆ Proportion of school clinics open at least 40 hours per week
- ◆ Proportion of school clinics with available and functional clinic equipment
- ◆ Proportion of students reporting frequent practice of FP/RH procedures during clinical rotation
- ◆ Proportion of students assessing clinics as providing sufficient opportunities to conduct

FP/RH procedures and counseling services with clients

- ◆ Proportion of school clinics in which equipment and gloves are properly soaked in chlorine after use
- ◆ Proportion of school clinics in which client privacy is ensured for counseling and examination
- ◆ Proportion of school clinics in which medical records indicate method dispensed to clients

Institutionalization Indicators

Availability of Trained FP/RH Faculty

- ◆ Proportion of faculty who received TRH Project CTS training and are assigned to teach the clinical portion of the course
- ◆ Average number of years of teaching for clinical instructors as compared to classroom instructors
- ◆ Government accreditation of clinical instructors as service providers of FP/RH services

Implementation of the FP/RH Curriculum

- ◆ Proportion of schools in which student competency is assessed and documented
- ◆ Proportion of students ever assessed as competent in conducting pelvic examinations
- ◆ Proportion of students ever assessed as competent in IUD insertion
- ◆ Proportion of students reporting that checklists were used to assess competency
- ◆ Proportion of students reporting access to anatomic models
- ◆ Proportion of students reporting sufficient time to practice with anatomic models
- ◆ Proportion of students reporting sufficient FP/RH library reference materials
- ◆ Proportion of students required to read FP/RH reference materials
- ◆ Proportion of clinical instructors with formal designation
- ◆ Inclusion of FP/RH questions in licensure examinations
- ◆ Leadership role of APSOM and ADPCN in preservice education policy development

Utilization of School Clinics

- ◆ Proportion of school clinics that provide services in addition to FP/RH services
- ◆ Proportion of school clinics that are service delivery points of the government's Family Planning Program

APPENDIX B

FP Curriculum Covers

